STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare recertification survey conducted at your facility on July 6, 2009 through July 10, 2009, in accordance with 42 CFR Chapter IV Part 483 Requirements for Long Term Care Facilities. The census was 70 residents. The sample size was extended to 20 sampled residents which included 2 closed records. The facility was found in sub-standard non-compliance at 483.13 Resident Behavior and Facility Practices. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1	F 157		

existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to notify an interested family member of a significant event for 1 of 20 residents (Resident #1).

Findings include:

Resident #1

Resident #1 was admitted to the facility on 5/11/07 with diagnoses that included dementia, hypertension and failure to thrive.

An allegation was made that Resident #1 had been sexually assaulted in the facility on or about 5/27/09. The resulting investigation by both the facility and the local police force determined the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 2 allegation was unfounded. Interview on 7/7/09 with facility administration revealed the resident's husband was not apprised of the situation.	F 157		
F 224 SS=G	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to prevent the mistreatment and neglect of 2 of 20 residents (Residents #11, #4). Findings include: Resident #11 Resident #11 was admitted to the facility on 11/17/06. Her diagnoses included dementia, anxiety, and chronic pain. She was basically non verbal and wheelchair bound. On 7/6/09 at approximately 11:35 AM at the main nurse's station, loud sobbing was heard. Looking about the immediate surroundings, Resident #11 was observed seated in her wheelchair with no staff noted approaching her. Tears were streaming down her face. When asked if she needed help the resident nodded her head, "Yes." When asked if in pain, the resident again nodded her head, "Yes." A female staff person was summoned from sitting at the desk, to help the resident. The staff member immediately approached Resident #11. As the staff person	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 3	F 224		

talked to the resident, Licensed Practical Nurse (LPN -Employee #11), who was also seated at the desk, called out to the staff person, "She is all right, you know she has that chronic thing and you can't understand her anyway. I was just with her a few minutes ago." The LPN then stated, "She cries all the time." The first staff person pushed the resident down the hall and returned several minutes later and stated , "I redirected her. I asked her if she wanted to watch Westerns." After immediately searching for Resident #11, the resident was observed in the nearly empty dining room of 200 Hall. The resident was seated at the dining table facing a window with closed blinds. No one else was observed at the table. A television, with a Western playing, was located in the adjoining living room. It could not be seen or heard by Resident #11.

Review of the record disclosed Resident #11 received Vicodin twice a day for chronic pain. A care plan for for complaints of chronic pain contained the following approaches:
- evaluate the effectiveness of pain management
- position for comfort as needed
- elevate feet if necessary
- monitor and record any complaints of pain.

Also present were care plans for anxiety and periodic crying. The care plan for anxiety had approaches to monitor for drug effectiveness, monitor resident's functional status each shift, and to quantitatively and objectively document the resident's behavior/mood.

The approaches for the episodes of crying included to change her brief after dinner for relief and comfort, test the temperature of the shower

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 4	F 224		

water and to give her a toy to hold, take for a walk outside, provide with a communication board for her aphasia, take extra time to allow her to express herself and to offer water for thirst.

There was no evidence any evaluation of the resident's status was undertaken or that any of the care plan approaches were utilized.

Resident #4

Resident #4 was originally admitted on 10/28/08, with a re-admission on 5/4/09. The resident's diagnoses included dementia, debility, cellulitis of the lower left leg, anemia, vitamin and vitamin B12 deficiency.

On 7/6/09, during the course of observing Resident #4 eating a mechanical soft diet, the resident took a long time in chewing the food. Upon closer observation of the resident it was noted that the resident was missing multiple teeth.

On 7/6/09, in an interview with the Graduate Nurse (Employee #12), the nurse confirmed Resident #4 had chewing problems, missing teeth and other dental needs which needed attention. The nurse indicated that the family had identified that the resident was having difficulty eating and had requested a diet change, which had been changed to mechanical soft diet. The nurse also indicated that she thought that the family was looking into getting the resident a dental appointment.

Review of the resident's Minimum Data Set (MDS) assessments, starting with the initial

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 5	F 224		

admission assessment with reference date of 11/07/08, followed by a significant change assessment with reference date of 5/11/09 and a quarterly assessment with a reference date of 6/2/1/09, revealed on all occasions that Section L. Oral/Dental Status did not indicate the resident's appropriate status of natural and lost/missing teeth. The indicator in this section, on all occasions, was coded with "f" which indicated the resident needed daily cleaning of teeth/denture or daily mouth care-by resident or staff. The MDS indicated the resident was severely cognitively impaired in decision making.

On 7/6/09, review of Resident #4's Observation Details records from 11/11/08 through 5/19/09, documented by both the facility's dietary supervisor and dietician the resident had only been consuming 25% of her meals and had chewing problems. A Progress Note documented on 5/19/09, by the dietician that the resident had lost 10 pounds in a 5 to 6 month period.

Review of Resident #4's weight record revealed an admission weight on 10/28/08 of 133 pounds, by 12/26/08 the resident had lost seven pounds with a weight of 126 pounds. The resident continued to lose weight and on 5/7/09 was down to 115 pounds. Over a three month period the resident had a 5.3% weight loss, with an overall 14% weight loss over six months.

Review of an entry in Resident #4's Progress Notes, dated the morning of 5/06/09 by a licensed nurse, indicated that a nursing assistant notified the nurse the resident was bleeding from the mouth. The note indicated the licensed nurse examined the resident's mouth and identified the resident had rotten broken teeth.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 6 A Care Conference note dated 6/11/09 indicated that the family stated the resident needed to be evaluated for removal of teeth and expressed concern the resident may have needed pain medication for multiple reasons. Among family members and other facility staff, the care conference held on 6/11/09 was attended by the facility's MDS coordinator, Social Worker, Director of Nursing, and Food Services Director. On 7/9/09, in an interview with the facility's Dietary Supervisor (Employee #5) to discuss Resident #4's dental, chewing and weight loss concerns, the supervisor indicated she was not aware the resident's weight loss should have been care planned. The supervisor indicated she was also not aware of the association or possible relationship of the dental concerns in contributing to the resident's chewing difficulties and weight loss, or the need to have these concerns addressed to prevent future weight loss. Resident #4's medical record failed to reveal a care plan(s) to address the dental issues, chewing problems, pain associated with dental concerns, the progressive weight loss or the need for a dental appointment.	F 224		
F 225 SS=H	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 7 indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, personnel record review, interview, and document review, the facility failed to report and thoroughly investigate and prevent further potential abuse while investigation was in progress of allegations involving mistreatment, neglect, abuse, and injury of unknown origin or events with significant/suspicious injury for 5 of 20 residents (Residents #1, #14, #16, #18, #19).	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 8	F 225		

Findings include:

Resident #16

Resident #16 was originally admitted on 3/09/07 with a re-admit on 5/11/09. Diagnoses included chronic airway obstruction, dementia, hypertension and congestive heart failure, and had difficulty walking.

Progress notes dated 6/23/09 at 11:23 AM, documented the resident "stood up from wheel chair and fell on right side. Noted laceration to right eye. Resident will not response to any questions." It was further documented that the physician was notified and non emergent transport was called.

Documentation at 11:40 AM, reported Resident #16 had symptoms of a seizure and was sent to the hospital at 11:55 AM. There was no additional charting in the progress notes. The resident's face sheet revealed the resident was discharged from the facility at 11:40 AM on 6/23/09.

On 7/09/09 at 10:15 AM, an interview with Employee #1 and #2 revealed Resident #16 had expired in the hospital. When asked why the incident was noted on the facility's event log but was not reported to the appropriate agencies, they both responded that they were unaware that witnessed events had to be reported to any of the agencies.

Resident #1

Resident #1 was admitted to the facility on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 9	F 225		

5/11/07 with diagnoses that included dementia, hypertension and failure to thrive.

A complaint was received which alleged the resident had been sexually assaulted during the evening of 5/27/09, by a male resident of the facility.

Review of the facility's event log disclosed that the allegation was entered on the log, but that the event had never been reported to any agency as mandated.

On 7/7/09 at 2:20 PM, the administrator revealed she completed an internal investigation after the allegation was reported to her on 5/28/09. The investigation consisted of interviewing staff as well as the alleged victim's roommate who made the allegation. The administrator had Resident #1 examined physically, by the Director of Nursing. The resident was not interviewable due to her advanced state of dementia. The administrator's deduction was there was no validity to the allegation and therefore treated the event as an incident. The allegation of a sexual assault was not reported to the local law enforcement until the Division for Aging Services (Ombudsman) became involved. The police, after their investigation, closed the case because they did not feel that any crime had been committed. The administrator felt, based on her own internal investigation and the police investigation, that the allegation had not occurred, and did not believe this was a reportable incident since it was unsubstantiated.

The facility's policy on "Abuse Prohibition," revised 2/05, stated that if the incident involved alleged abuse or neglect, "the Administrator shall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 10	F 225		

provide the Bureau of Licensure and Certification (BLC) and the Division of Aging Services Ombudsman Office (DAS) with initial notice of the alleged abuse or neglect. The notification will occur within 24 hours after the incident becomes known." The policy also defined abuse as verbal, sexual, physical, including corporal punishment, neglect, misapporation of property and involuntary seclusion.

The terms of the investigation defined in the same policy included interviews of all involved parties or potential witnesses by two interviewees if possible. Signed statements were to be obtained from these parties. Documentation in the resident's medical report should include the nature and extent of any injuries incurred, whether the resident was sent to the hospital and if the physician was notified. After the internal investigation was completed, the findings should be reported to BLC and DAS within five working days. The administrator was unable to provide documentation of interviews from involved parties, the police report or a summary of the administrator's internal investigation.

Resident #18

On 7/9/09, review of the facility's Resident Accident & Incident Reports log revealed an entry dated 6/29/09, for Resident #18, which indicated the resident had fallen and was sent to the hospital for an evaluation. The log further indicated that the Bureau of Health Care Quality and Compliance (state agency previously known as Bureau of Licensure and Certification (BLC)) was not notified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 11	F 225		

Resident #18's medical record revealed an Event Report entry on 6/29/09 at 10:53 AM. The description identified the resident was on the ground when the nurse came and staff stated the resident hit her head and hip.

The progress note dated 6/29/09 at 11:00 AM, indicated neuro checks were done. The resident had a grimacing expression on her face while walking and transferring back to bed and that the resident was transported by ambulance to the hospital at 10:53 AM. The note also indicated the resident's daughter and son were informed of the incident. A progress note at 3:24 PM, indicated the resident returned from the hospital and had a contusion (bruise) on the left shoulder.

Further review of Resident #18's medical record revealed a history of falls. Review of Resident #18's care plan, with a problem start date of 3/18/09, documented the resident was at increased risk for falls due to senile psychosis, unsteady gait, cognitive impairment, psychotropic drug use and history of falls. The care plan goals and approaches were dated 6/19/09, and had not been updated following the 6/29/09 event. There was an approach list which indicated there was to be a Tab alarm on the bed. The goals and approaches failed to address medication assessment, physical therapy evaluation or other preventative measures.

On 7/9/09, in an interview with the administrator (Employee #1), the administrator indicated that she was not sure why the 6/29/09 event which required Resident #18 to be evaluated at the emergency room, had not been reported to the state agency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 12	F 225		

In a later interview with both the administrator (Employee #1) and the Director of Nursing (DON) (Employee #2) on 7/9/09, the administrator and DON indicated that they were not aware the event was required to be reported.

Resident #19

Review of the facility's Resident Accident & Incident Reports log on 7/9/09 revealed an entry dated 6/30/09 with the following documentation: "head laceration and swelling to right hip; transported to hospital." The log indicated the Bureau of Health Care Quality and Compliance (state agency) was not notified of the event/injury.

Review of Resident #19's medical record revealed an Event report entry on 6/30/09 at 2:20 PM, and included the following description: "At 2:15 PM, was called to resident room. Resident was lying on floor on her back. Large amount of red blood pooling under her head. Pressure applied to back of head. Moves arms and legs without distress. Has large loose fluid sac on right hip. Aides state this is new..." Progress notes dated 6/30/09 indicated that the resident's physician had called for an order to transfer her to the Emergency Room, and that she had returned at 4:48 PM in stable condition.

The care plan for Resident #19 revealed the resident had a history of falls and was at increased risk for falls due to cognitive deficit, unsteady gait, and generalized weakness. The goal indicated on the care plan was the resident "will not have any injury in relation to falls by next revision date." The care plan indicated a goal target date of 6/9/09, which had not been updated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 13	F 225		

following the 6/20/09 event.

In an interview on 7/9/09 with the administrator, Employee #1, and the Director of Nursing (DON), Employee #2, the administrator and DON indicated they were unaware that significant events requiring residents to be sent out of the facility for medical attention were to be reported to the state agency.

Resident #14

On 5/25/09 at 10:00 AM, a licensed practical nurse (LPN), Employee #14 noted in the record that Resident #14 was kicked by another resident. On 7/9/09, Employee #14 revealed although she was aware a resident-to-resident event needed to be reported to the administrator, she did not reported this event. Employee #14 could offer no explanation why it was not reported. The administrator revealed she was present in the facility the day of the resident-to-resident event. The administrator denied any knowledge of the event, confirming no investigation was conducted.

Document review revealed the facility's policy contained the seven components of screening, training, prevention, identification, investigation, protection and reporting/response.

The facility was unable to provide evidence that employees recognized alleged abuse or neglect to report, or were able to return a demonstration of their comprehension of the training.

In separate interviews with the activity staff, Employee #4 and Employee #15 on 7/7/09, both acknowledged they had no abuse and neglect

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 14	F 225		

training in over three years, although their education records revealed they had this training on a yearly basis.

Interview with the administrator and the Director of Nursing (DON) on 7/7/09, revealed a failure to report events requiring a resident to be transferred to a hospital or other facility for further evaluation after a fall or event. The administrator and the DON acknowledged they were not aware an event with significant injury was defined as one that required the resident to be sent out of the facility for medical attention.

The facility policy Section F: 6) described the facility was to notify the state agencies of "any injury of unknown source, which has or is likely to have a significant effect on the health, safety or welfare of a resident. Injuries requiring the services of a physician, hospital, police or fire department on an emergency basis shall be reported to the Bureau" (state agency - Bureau of Health Care Quality and Compliance).

A review of the facility policy regarding protection of residents indicated that a staff member who was alleged to have a staff-to-resident event was to be suspended immediately.

On 7/7/09, the administrator and the social worker revealed they had become aware an allegation was received concerning a staff-to-resident physical altercation. The staff member involved was not scheduled to work for several days. The administrator and the social worker were not planning to suspend during the investigation. The administrator and social worker thought they could complete the investigation before the social worker returned to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 15 work. The administrator and social worker acknowledged by not suspending, the staff member could be called into work and place residents at risk for potential harm. The administrator and social worker agreed the policy was specific, that employees would be suspended immediately. There were no qualifiers or exceptions in the policy.	F 225		
F 226 SS=H	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on clinical record review, personnel record review, interview, and document review, the facility failed to follow their Abuse and Neglect policy and protect, investigate, identify and report suspected abuse and neglect events, or events with significant/suspicious injury for 5 of 20 residents (Residents #1, #14, #16, #18, #19). The facility failed to perform background screening timely for 6 of 11 personnel files (Personnel records #3, #4, #6, #7, #8, #10). Findings include: Resident #16 Resident #16 was originally admitted on 3/09/07 with a re-admit on 5/11/09. Diagnoses included chronic airway obstruction, dementia, hypertension and congestive heart failure, and had difficulty walking.	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 16	F 226		

Progress notes dated 6/23/09 at 11:23 AM, documented the resident "stood up from wheel chair and fell on right side. Noted laceration to right eye. Resident will not response to any questions." It was further documented that the physician was notified and non emergent transport was called.

Documentation at 11:40 AM, reported Resident #16 had symptoms of a seizure and was sent to the hospital at 11:55 AM. There was no additional charting in the progress notes. The resident's face sheet revealed the resident was discharged from the facility at 11:40 AM on 6/23/09.

On 7/09/09 at 10:15 AM, an interview with Employee #1 and #2 revealed Resident #16 had expired in the hospital. When asked why the incident was noted on the facility's event log but was not reported to the appropriate agencies, they both responded that they were unaware that witnessed events had to be reported to any of the agencies.

Resident #1

Resident #1 was admitted to the facility on 5/11/07 with diagnoses that included dementia, hypertension and failure to thrive.

A complaint was received which alleged the resident had been sexually assaulted during the evening of 5/27/09, by a male resident of the facility.

Review of the facility's event log disclosed that the allegation was entered on the log, but that the event had never been reported to any agency as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 17	F 226		

mandated.

On 7/7/09 at 2:20 PM, the administrator revealed she completed an internal investigation after the allegation was reported to her on 5/28/09. The investigation consisted of interviewing staff as well as the alleged victim's roommate who made the allegation. The administrator had Resident #1 examined physically, by the Director of Nursing. The resident was not interviewable due to her advanced state of dementia. The administrator's deduction was there was no validity to the allegation and therefore treated the event as an incident. The allegation of a sexual assault was not reported to the local law enforcement until the Division for Aging Services (Ombudsman) became involved. The police, after their investigation, closed the case because they did not feel that any crime had been committed. The administrator felt, based on her own internal investigation and the police investigation, that the allegation had not occurred, and did not believe this was a reportable incident since it was unsubstantiated.

The facility's policy on "Abuse Prohibition," revised 2/05, stated that if the incident involved alleged abuse or neglect, "the Administrator shall provide the Bureau of Licensure and Certification (BLC) and the Division of Aging Services Ombudsman Office (DAS) with initial notice of the alleged abuse or neglect. The notification will occur within 24 hours after the incident becomes known." The policy also defined abuse as verbal, sexual, physical, including corporal punishment, neglect, misapporation of property and involuntary seclusion.

The terms of the investigation defined in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 18	F 226		

same policy included interviews of all involved parties or potential witnesses by two interviewees if possible. Signed statements were to be obtained from these parties. Documentation in the resident's medical report should include the nature and extent of any injuries incurred, whether the resident was sent to the hospital and if the physician was notified. After the internal investigation was completed, the findings should be reported to BLC and DAS within five working days. The administrator was unable to provide documentation of interviews from involved parties, the police report or a summary of the administrator's internal investigation.

Resident #14

On 5/25/09 at 10:00 AM, a licensed practical nurse (LPN), Employee #14 noted in the record that Resident #14 was kicked by another resident. On 7/9/09, Employee #14 revealed although she was aware a resident-to-resident event needed to be reported to the administrator, she did not reported this event. Employee #14 could offer no explanation why it was not reported. The administrator revealed she was present in the facility the day of the resident-to-resident event. The administrator denied any knowledge of the event, confirming no investigation was conducted.

Document review revealed the facility's policy contained the seven components of screening, training, prevention, identification, investigation, protection and reporting/response.

The facility's policy and practice to ensure residents were protected was to submit fingerprints of new employees within 10 days after their hire date, and to request reference checks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 19	F 226		

Review of 11 personnel records with the Human Resources Director revealed:

Personnel record #3 was hired on 7/31/06, but there was no reference checks. Her fingerprints were not obtained until 8/24/06.

Personnel record #4 was hired on 2/1/09. Her fingerprints were not obtained until 3/20/09.

Personnel record #6 was hired on 7/17/07. Her fingerprints were not obtained until 1/30/08.

Personnel record #7 was hired on 9/12/06. There was no record of reference checks or professional references in her personnel file.

Personnel record #8 was hired on 5/21/08. Her fingerprints were not obtained until 7/10/08.

Personnel record #10 was hired in 6/4/08. There was no evidence of reference checks in his personnel file.

On 7/9/09, the Human Resources Director revealed, individual managers were informed they needed to obtain the fingerprints for the background checks.

The facility was unable to provide evidence that employees recognized alleged abuse or neglect to report, or were able to return a demonstration of their comprehension of the training.

In separate interviews with the activity staff, Employee #4 and Employee #15 on 7/7/09, both acknowledged they had no abuse and neglect training in over three years, although their

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 20	F 226		

education records revealed they had this training on a yearly basis.

Interview with the administrator and the Director of Nursing (DON) on 7/7/09, revealed a failure to report events requiring a resident to be transferred to a hospital or other facility for further evaluation after a fall or event. The administrator and the DON acknowledged they were not aware an event with significant injury was defined as one that required the resident to be sent out of the facility for medical attention.

The facility policy Section F: 6) described the facility was to notify the state agencies of "any injury of unknown source, which has or is likely to have a significant effect on the health, safety or welfare of a resident. Injuries requiring the services of a physician, hospital, police or fire department on an emergency basis shall be reported to the Bureau" (state agency - Bureau of Health Care Quality and Compliance).

A review of the facility policy regarding protection of residents indicated that a staff member who was alleged to have a staff-to-resident event was to be suspended immediately.

On 7/7/09, the administrator and the social worker revealed they had become aware an allegation was received concerning a staff-to-resident physical altercation. The staff member involved was not scheduled to work for several days. The administrator and the social worker were not planning to suspend during the investigation. The administrator and social worker thought they could complete the investigation before the social worker returned to work. The administrator and social worker

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 21	F 226		

acknowledged by not suspending, the staff member could be called into work and place residents at risk for potential harm. The administrator and social worker agreed the policy was specific, that employees would be suspended immediately. There were no qualifiers or exceptions in the policy.

Resident #18

On 7/9/09, review of the facility's Resident Accident & Incident Reports log revealed an entry dated 6/29/09, for Resident #18, which indicated the resident had fallen and was sent to the hospital for an evaluation. The log further indicated that the Bureau of Health Care Quality and Compliance (state agency previously known as Bureau of Licensure and Certification (BLC)) was not notified.

Resident #18's medical record revealed an Event Report entry on 6/29/09 at 10:53 AM. The description identified the resident was on the ground when the nurse came and staff stated the resident hit her head and hip.

The progress note dated 6/29/09 at 11:00 AM, indicated neuro checks were done. The resident had a grimacing expression on her face while walking and transferring back to bed and that the resident was transported by ambulance to the hospital at 10:53 AM. The note also indicated the resident's daughter and son were informed of the incident. A progress note at 3:24 PM, indicated the resident returned from the hospital and had a contusion (bruise) on the left shoulder.

Further review of Resident #18's medical record revealed a history of falls. Review of Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 22	F 226		

#18's care plan, with a problem start date of 3/18/09, documented the resident was at increased risk for falls due to senile psychosis, unsteady gait, cognitive impairment, psychotropic drug use and history of falls. The care plan goals and approaches were dated 6/19/09, and had not been updated following the 6/29/09 event. There was an approach list which indicated there was to be a Tab alarm on the bed. The goals and approaches failed to address medication assessment, physical therapy evaluation or other preventative measures.

On 7/9/09, in an interview with the administrator (Employee #1), the administrator indicated that she was not sure why the 6/29/09 event which required Resident #18 to be evaluated at the emergency room, had not been reported to the state agency.

In a later interview with both the administrator (Employee #1) and the Director of Nursing (DON) (Employee #2) on 7/9/09, the administrator and DON indicated that they were not aware the event was required to be reported.

Resident #19

Review of the facility's Resident Accident & Incident Reports log on 7/9/09 revealed an entry dated 6/30/09 with the following documentation: "head laceration and swelling to right hip; transported to hospital." The log indicated the Bureau of Health Care Quality and Compliance (state agency) was not notified of the event/injury.

Review of Resident #19's medical record revealed an Event report entry on 6/30/09 at 2:20 PM, and included the following description: "At

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 23 2:15 PM, was called to resident room. Resident was lying on floor on her back. Large amount of red blood pooling under her head. Pressure applied to back of head. Moves arms and legs without distress. Has large loose fluid sac on right hip. Aides state this is new..." Progress notes dated 6/30/09 indicated that the resident's physician had called for an order to transfer her to the Emergency Room, and that she had returned at 4:48 PM in stable condition. The care plan for Resident #19 revealed the resident had a history of falls and was at increased risk for falls due to cognitive deficit, unsteady gait, and generalized weakness. The goal indicated on the care plan was the resident "will not have any injury in relation to falls by next revision date." The care plan indicated a goal target date of 6/9/09, which had not been updated following the 6/20/09 event. In an interview on 7/9/09 with the administrator, Employee #1, and the Director of Nursing (DON), Employee #2, the administrator and DON indicated they were unaware that significant events requiring residents to be sent out of the facility for medical attention were to be reported to the state agency.	F 226		
F 246 SS=D	483.15(e)(1) ACCOMMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	F 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 24	F 246		

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to accommodate needs of positioning and personal preferences for 4 of 20 residents (Residents #1, #2, #11, #14).

Findings include:

Resident #1

Resident #1 was admitted to the facility on 5/11/07 with diagnoses that included dementia, hypertension and failure to thrive.

On two occasions, the resident was observed in her wheelchair at the dining table. She was unable to sit upright and leaned severely to the side. Her husband and caregiver were present on both occasions. They were observed to "pull" her upright and place a pillow beside to keep her in position. When the husband was interviewed, he stated that he was afraid that Resident #11 would choke while being fed if he didn't change her position. There was no evidence that any accomodation was employed for the resident's positioning.

Resident #2

Resident #2 had been in the facility since 9/6/07. Diagnoses included dementia, osteoarthritis, and hypertension.

During the lunch time meal on 7/6/09, Resident #2 was observed transferred from her wheelchair to a regular dining chair in the 200 Hall dining room. The resident cried out loudly during the transfer process. During the remainder of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 25	F 246		

meal, she continued to cry and was observed leaned to one side.

Review of the record disclosed that on 5/29/09, an evaluation was completed by the physical therapist for positioning and seating while in the wheelchair. No documentation could be located as to the outcome of the evaluation.

During an interview on 7/7/09 at 10:30 AM, the physical therapist conveyed the resident's son would not support the use of any wheelchair restraints. The therapist did not document the results of the evaluation or the resident's son's wishes.

An order was written on 6/10/09 for comfort care. There was no definition of what constituted comfort care. There was no evidence that staff attempted to accommodate the resident's need for comfort in positioning.

Resident #11

Physician's orders revealed an open ended order written 5/4/08 for an arm rest right side of wheel chair when the resident was in the chair, for positioning. Also present was an open ended order written 6/3/08 for an anti thrust wedge cushion for positioning while in wheel chair.

Observation of Resident #11 at 11:35 AM on 7/6/09 and again on 7/7/09 revealed neither the right sided arm rest or the anti thrust wedge cushion.

In an interview on 7/9/09 at 11:15 AM, Employee #3 revealed both pieces of equipment should have been in place for the resident. At 11:40 AM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 26	F 246		

a telephone interview with the physical therapist (PT) revealed on the initial evaluation of Resident #11, the use of the arm rest and the anti thrust wedge was recommended, but after the implementation of the equipment, the PT did not feel they were beneficial for the resident. The PT further revealed approximately six months prior, he requested nursing to obtain orders to discontinue the use of the arm rest and the wedge. The PT did not document the change in his recommendations. He currently provided the resident with a wheelchair cushion and the use of a "stuffed animal" as an arm support. While the resident was noted to be seated on a cushion in the wheelchair, there was no support of any type for her flaccid right arm.

Resident #14

Resident #14 was readmitted to the facility on 5/10/07. His primary diagnoses included chronic obstructive pulmonary disease, diabetes, coronary artery disease and obesity. A physician's order on 12/14/0, indicated Resident #14 could have one beer, or one to two fingers of whiskey a day. He had a public guardian.

During an interview with Resident #14 on 7/7/09, he asked why he couldn't have a highball or drink every day. A review of his clinical record revealed Resident #14 kept alcohol and food products in his room. An intervention to remove all food and alcohol items from his room was initiated by the nursing staff. The alcohol was relocated to the nurse's station.

An interview with the Director of Nursing (Employee #2) on 7/9/09, confirmed the alcohol

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 27 had been removed from his room, and that all Resident #14 had to do was ask for a drink. Further review revealed the facility staff had a care conference on 7/1/09, which included the resident and his public guardian. The conclusion of this conference was that Resident #14 should be able to have his evening drink. Review of the medication administration record, nursing notes and care plan revealed no documentation that Resident #14 was offered his evening drink.	F 246		
F 248 SS=E	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, observation, record review and document review, the facility failed to ensure the activities programs were designed to meet individual interests and needs for 5 of 20 residents (Residents #10, #1, #2, #11, #16) and observed residents on the special care unit. Findings include: Observation on 7/6/09, in the special care unit revealed a group of women performing line dancing. Although approximately seven to nine residents were positioned so they could see the line dancers, five residents were seated away from this activity in a separated area. These five residents could not see the line dancers. The	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 28	F 248		

line dancing activity was observed for 20 minutes. There was no interaction between the performers and the residents. Three certified nursing assistants (CNAs) present did not try to engage the residents in this activity until the last five minutes when a CNA started dancing with a resident who had just walked in. When the dancers left, there was no interaction with the residents, such as verbal acknowledgement or physical gestures such as waving good-bye.

An interview with the line dance coordinator after the dancing revealed that they came to the facility to practice their routines.

Further review of the activity calendar in the special care unit revealed there were no times listed on the calendar or daily event board to assist residents with knowing what activities were planned and when they would occur.

An interview with the Employee #4 on 7/7/09, revealed that although she had the title of Activity Director, she had just started the training in April and had just completed her first class assignment. Employee #4 acknowledged she was not aware that as Activity Director, she was responsible for the entire facility activities program, including those on the special care unit.

Review of the resident council meeting minutes revealed concerns of the residents were forwarded to the various department managers, but responses were not timely to address the residents' concerns. Examples were:
- that maintenance and housekeeping department was informed after the 1/6/09 meeting the shower rooms were too cold "cold as a frog", the water was not always warm enough and the 200 dining

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 29 room was cold. - the showers were not cleaned often enough. The maintenance and housekeeping department reply was 3/2/09. - April resident council meeting on 4/28/09, continued to express that the rooms and dining rooms were not clean. There was also the continued complaint that room and water temps continued to be a problem. As of 7/7/09, housekeeping had not responded and maintenance's reply was dated 7/7/09. Resident #10 Record review revealed Resident #10 was blind, and required a merry walker to assist with her ambulation, and prevent injury. The activity log revealed the resident did not participate in volleyball or kickball. The log also described that she like to read and write. There was no documentation on how the activities had been revised to accommodate her blindness. Review of the quarterly assessments for Residents #1, 2, 11, and 16, disclosed the summaries to be very brief and lacked documentation as to what activities the residents participated in, how their participation compared to the previous quarter, if the residents had expressed any particular interest in specific activities or how involved the residents were in the individual activities and how the activities person planned to increase the involvement of the residents in activities for the coming quarter.	F 248		
F 249 SS=D	483.15(f)(2) ACTIVITY DIRECTOR QUALIFICATIONS The activities program must be directed by a	F 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 249	Continued From page 30	F 249		

qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the State in which practicing; and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State.

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure the Activity Consultant complied with her contract for services.

Findings include:

Interview with the Activity Director (Employee #4) and the Special Care Unit Coordinator (Employee #6) on 7/7/09 and 7/9/09, revealed the Activity Consultant was at the facility approximately once every three months. Both acknowledged they did not communicate regularly with the Activity Consultant.

A review of the Activity Consultant's job description, dated effective 9/2/08, contained the following:
"3) Provide a written report to the Administrator monthly."
"6) Provide an initial visit with a maximum of six (6) hours and four (4) to six (6) hours quarterly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 249	Continued From page 31 thereafter." This contract was signed by the Activity Consultant on 10/9/08. A review of the submitted consultant reports revealed the Activity Consultant visited the facility on 1/9/09 and 4/17/09. These were the only records of the Activity Consultant. An interview with the Corporate staff (Employee #3) on 7/8/09, revealed she could not provide a reason as to why the contract indicated monthly reports but only quarterly visits were conducted. The corporate staff indicated the "monthly report" was an error in typing. It also could not be determined why the visits started approximately three months after the contract was signed.	F 249		
F 272 SS=B	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions;	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 32 Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to conduct comprehensive assessments of the residents within the correct Assessment Reference Date or look back period for 3 of 20 residents (Resident #1, #2, #11), and the Minimum Data Set (MDS) for 2 of 20 residents were not completed within the mandated time frames (Residents #1, #2). Findings include: Resident #1 was admitted to the facility on 5/11/07 with diagnoses that included dementia, hypertension and failure to thrive. Review of the Minimum Data Set (MDS) with a completion date of 10/23/09 revealed that the Assessment Reference Date (ARD) or look back ended on 10/23/09. This indicated that the MDS was completed by facility staff prior to the look back period being completed. By completing the MDS early, the staff may have failed to capture significant data pertinent to the outcome of the MDS.	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 33	F 272		

A quarterly MDS was completed for Resident #1 on 10/23/09. The next MDS reviewed was identified as an annual assessment completed on 4/26/09. There was a six month period between the quarterly and annual assessment instead of the required four month time frame.

Resident #2 had been in the facility since 9/6/07. Diagnoses included dementia, osteoarthritis, and hypertension.

Review of a quarterly MDS completed on 11/20/09, showed a look back period ending 11/20/09. This indicated that the MDS was completed by facility staff prior to the look back period being completed. By completing the MDS early, the staff may have failed to capture significant data pertinent to the outcome of the MDS. One of signatures of a person completing a portion of the MDS was not until 7/06/09, eight months later.

The next quarterly MDS was not completed until 5/19/09 or 7/06/09, depending on which signatures and dates one looked at. The quarterly MDS was either seven or nine months late. Two of the disciplines completing their portion of the MDS, completed their part prior to the end of the last day of the look back period.

Resident #11 was admitted to the facility on 11/17/06. Her diagnoses included dementia, anxiety, and chronic pain. She was basically non verbal and wheelchair bound.

Review of an annual MDS dated 10/08/08 indicated that the MDS was completed before the end of day, of the look back period (10/08/08), had finished. By completing the MDS early, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 34 staff may have failed to capture significant data pertinent to the outcome of the MDS. The next MDS, denoted as a quarterly, was completed 1/6/09. The last date of the look back period was also the same date as the completion date. Interviews were conducted with Employee #3 on several occasions during the survey. She acknowledged several problems with the MDS and was working with the current MDS Coordinator to correct any problems associated with the assessments.	F 272		
F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 35 Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the accuracy of the comprehensive and quarterly assessments for 3 of 20 residents (Residents #3, #4, #14). Findings include: Resident #4 On 7/6/09, during the course of observing Resident #4 eating a mechanical soft diet, the resident took a long time in chewing the food. Upon closer observation of the resident it was noted that the resident was missing multiple teeth. On 7/6/09, in an interview with the nurse (Employee #11), the nurse confirmed Resident #4 had chewing problems, missing teeth and other dental needs which needed attention. The nurse indicated that the family had identified that the resident was having difficulty eating and had requested a diet change, which had been changed to mechanical soft diet. The nurse also indicated that she thought that the family was looking into getting the resident a dental appointment. Review of Resident #4's medical record revealed that the resident was originally admitted on 10/28/08, with a re-admission on 5/4/09. Review of the resident's Minimum Data Set (MDS) assessments, starting with the initial admission	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 36 assessment with reference date of 11/07/08, followed by a significant change assessment with reference date of 5/11/09 and a quarterly assessment with a reference date of 6/2/1/09, revealed on all occasions that Section L. Oral/Dental Status did not indicate the resident's appropriate status of lost/missing teeth. The indicator in this section, on all occasions, was coded with "f" which indicated the resident needed daily cleaning of teeth/denture or daily mouth care-by resident or staff. Resident #14 The resident's clinical record revealed he had a public guardian. The annual comprehensive assessment on 3/14/08, confirmed this. The annual assessment completed on 2/24/09, indicated Resident #14 was his own responsible party. Resident #3 The initial comprehensive assessment was completed on 4/10/09. The assessment indicated that 1/2 side rails were being used as a restraint. There were no consents for the restraints, assessment or care plan for the restraints. The resident assessment profile was not triggered that the half side rails had been identified as restraints. Random interviews with the staff on the special care unit denied the side rails were being used for restraints.	F 278		
F 279 SS=G	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 37 comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop care plans based on resident assessment for 2 of 20 residents regarding swallowing problems (Residents #1, #2), for 1 of 20 residents regarding positioning (Resident #2), and for 1 of 20 residents regarding dental care, chewing problems and weight loss (Resident #4). Findings include: Resident #4 Resident #4 was originally admitted on 10/28/08, with a re-admission on 5/4/09. The resident's diagnoses included dementia, debility, cellulitis of the lower left leg, anemia, vitamin and vitamin	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 38	F 279		

B12 deficiency.

On 7/6/09, during the course of observing Resident #4 eating a mechanical soft diet, the resident took a long time in chewing the food. Upon closer observation of the resident it was noted that the resident was missing multiple teeth.

On 7/6/09, in an interview with the Graduate Nurse (Employee #12), the nurse confirmed Resident #4 had chewing problems, missing teeth and other dental needs which needed attention. The nurse indicated that the family had identified that the resident was having difficulty eating and had requested a diet change, which had been changed to mechanical soft diet. The nurse also indicated that she thought that the family was looking into getting the resident a dental appointment.

Review of the resident's Minimum Data Set (MDS) assessments, starting with the initial admission assessment with reference date of 11/07/08, followed by a significant change assessment with reference date of 5/11/09 and a quarterly assessment with a reference date of 6/2/1/09, revealed on all occasions that Section L. Oral/Dental Status did not indicate the resident's appropriate status of natural and lost/missing teeth. The indicator in this section, on all occasions, was coded with "f" which indicated the resident needed daily cleaning of teeth/denture or daily mouth care-by resident or staff. The MDS indicated the resident was severely cognitively impaired in decision making.

On 7/6/09, review of Resident #4's Observation Details records from 11/11/08 through 5/19/09,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 39	F 279		

documented by both the facility's dietary supervisor and dietician the resident had only been consuming 25% of her meals and had chewing problems. A Progress Note documented on 5/19/09, by the dietician that the resident had lost 10 pounds in a 5 to 6 month period.

Review of Resident #4's weight record revealed an admission weight on 10/28/08 of 133 pounds, by 12/26/08 the resident had lost seven pounds with a weight of 126 pounds. The resident continued to lose weight and on 5/7/09 was down to 115 pounds. Over a three month period the resident had a 5.3% weight loss, with an overall 14% weight loss over six months.

Review of an entry in Resident #4's Progress Notes, dated the morning of 5/06/09 by a licensed nurse, indicated that a nursing assistant notified the nurse the resident was bleeding from the mouth. The note indicated the licensed nurse examined the resident's mouth and identified the resident had rotten broken teeth.

A Care Conference note dated 6/11/09 indicated that the family stated the resident needed to be evaluated for removal of teeth and expressed concern the resident may have needed pain medication for multiple reasons. Among family members and other facility staff, the care conference held on 6/11/09 was attended by the facility's MDS coordinator, Social Worker, Director of Nursing, and Food Services Director.

On 7/9/09, in an interview with the facility's Dietary Supervisor (Employee #5) to discuss Resident #4's dental, chewing and weight loss concerns, the supervisor indicated she was not aware the resident's weight loss should have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 40	F 279		

been care planned. The supervisor indicated she was also not aware of the association or possible relationship of the dental concerns in contributing to the resident's chewing difficulties and weight loss, or the need to have these concerns addressed to prevent future weight loss.

Resident #4's medical record and care plan failed to reveal a care plan(s) to address the dental issues, chewing problems, pain associated with dental concerns, the progressive weight loss or the need for a dental appointment.

Resident #1

Resident #1 was admitted to the facility on 5/11/07 with diagnoses including dementia, hypertension and failure to thrive.

The annual Minimum Data Set (MDS) completed on 4/26/09 identified the resident as having a swallowing problem. On two occasions, the resident was observed in her wheelchair at the dining table. She was unable to sit upright and leaned severely to the side. Her husband and caregiver were present on both occasions. They were observed to "pull" her upright and place a pillow beside to keep her in position. When the husband was interviewed, he stated that he was afraid that Resident #1 would choke while being fed if he didn't change her position. There was no evidence that a care plan was developed for the problem of swallowing.

Resident #2

Resident #2 had been in the facility since 9/6/07. Diagnoses included dementia, osteoarthritis, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 41	F 279		

hypertension.

The quarterly MDS completed on 11/20/08, identified Resident #2 as having a swallowing problem. There was no evidence of a care plan for the swallowing problem.

During the lunch time meal on 7/6/09, it was observed that Resident #2 was transferred from her wheelchair to a regular dining chair in the 200 Hall dining room. The resident cried out loudly during the transfer process . During the remainder of the meal, she continued to cry and was noted to be leaning to one side. There was no evidence of a care plan addressing the positioning problem.

Resident #14

An interview with the social worker (Employee #7) on 7/9/09, confirmed she was involved in the care conferences of the residents. She confirmed that the current care plans of the residents were not reviewed or updated during these care conferences.

The social worker confirmed that an unscheduled care conference was held on 7/1/09. This care conference was conducted to address Resident #14 hiding food and alcohol in his room, medication contraindications as well as the safety of other residents. Staff present were the Director of Nursing, the Administrator, Activities Director, Dietary manager and the Social Worker as well as Resident #14, his public guardian and the local Ombudsman. Pain management, medication compliance and alcohol use were discussed and agreed upon to ensure Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 42 #14 would have the highest practicable mental and psychosocial well-being. There was no change to the care plan. The social worker acknowledged that even with the care conference intervention, Resident #14's care plan was not reviewed or revised to reflect the agreed upon interventions.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that care plans were periodically reviewed and revised for 2 of 20 residents (Residents #8, #15).	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 43	F 280		

Findings include:

Resident #8

Resident #8 was admitted to the facility on 7/2/08. His current care plan included the following problem, with a start date of 7/2/08: "(The resident) has potential for aspiration due to swallowing problems related to diagnosis of dysphagia." One of the listed approaches to this problem, also with a start date of 7/2/08, was "Provide proper diet per MD pureed."

Record review of the resident's record revealed that a pureed diet had been ordered for the resident upon admission, but had then been discontinued on 7/21/08 after an evaluation by the Speech Therapist, and was changed to a mechanical soft diet. This change had not been noted in the care plan.

Resident #15

Resident #15 was initially admitted to the facility on 6/21/07, with readmission on 9/8/08. Her current care plan included the following problem: "Resident is at nutritional risk due to variable PO (by mouth) intake, dementia, anxiety, history of anemia, anorexia. Diet change 5/8/09 mechanical soft." One of the listed approaches to this problem, with a start date of 3/25/09 was "Will provide reg/pureed per MD order in RA dining." This approach had not been updated to reflect the current diet order, and there was no evidence of there ever being an order for a pureed diet.

In an interview on 7/10/09 at 12:00 PM, the Food Service Supervisor, Employee #5, indicated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 44 she had recently been given the responsibility of writing care plans pertaining to nutritional problems, and was uncertain as to why the care plans for Residents #8 and #15 had not been updated to reflect current diet orders and approaches.	F 280		
F 286 SS=C	483.20(d) RESIDENT ASSESSMENT - USE A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that resident assessments were completed and maintained as required for 18 of 20 residents (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #13, #14, #15, #17, #18, #19, #20). Findings include: Review of Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #13, #14, #15, #17, #18, #19, #20's Minimum Data Sets (MDS), revealed that MDS assessments were not completed as required and did not have the required 15 months of MDS assessments in the residents' records. On 7/11/09, an interview with the facility's Corporate Quality Assurance Nurse (Employee #3), revealed the previous MDS coordinator initiated a number of MDS assessments, but had failed to complete them. The Quality Assurance Nurse indicated the facility ran a report on the outstanding MDS assessments and had determined they were behind by 400	F 286		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 286	Continued From page 45 assessments. The Quality Assurance Nurse indicated she was working with the new MDS coordinator to complete the outstanding MDSs that were started, with plans to meet federal requirements. During a comprehensive record review on 7/6/09, it was determined there were no minimum data set (MDS) resident assessments available for the resident either in the clinical paper or computer patient record. An interview with the Corporate Quality Assurance Nurse (Employee #3) on 7/6/09, revealed the facility was behind over 400 MDS assessments. Employee #3 reported the previous MDS staff were not completing the MDSs as required. The new MDS coordinator was attempting to become current, and correct the situation.	F 286		
F 309 SS=E	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to put effective communication systems into place in order to ensure that 3 of 20 residents attained his/her highest practicable physical and psychosocial	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 46	F 309		

well-being (Resident #15, #8, #6).

Findings include:

Resident #15

Resident #15 was initially admitted to the facility on 6/21/07 with a readmission on 9/8/08, with diagnoses including dementia, depressive disorder, and muscle weakness.

A review of the resident's record revealed that an order had been changed on 6/7/09 from a regular diet to a mechanical soft diet. On 6/30/09, the facility's consultant dietitian wrote in the resident's chart that "Rt (resident) now receiving a mechanical diet."

In an interview with the food service director, Employee #5, on 7/10/09 at 12:00 PM, it was discovered that Resident #15 was still receiving a regular diet. Employee #5 indicated that she had not been informed by nursing that there had been an diet order change for the resident. She stated, "Two weeks ago we started using a red folder for nursing to use for the diet change forms. Before that they would sometimes tape the new orders to my door. Sometimes I'd get the orders and sometimes I didn't."

The care conference notes of 6/19/09 for Resident #15 were reviewed, and the following was documented: "She continues on Zyprexa, but has declined and is now experiencing difficulty swallowing despite Aricept...Will place resident on dietitian's list for eval of present diet texture as well as ST (Speech Therapy) for swallow eval." An order for a swallow evaluation by the speech therapist was created on 6/19/09. As of 7/10/09,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 47	F 309		

there was no evidence that the resident had been evaluated by the speech therapist.

The Quality Assurance Nurse, Employee #3 confirmed that no swallow evaluation had been completed. She further revealed that the resident's family had refused the evaluation, but that the refusal had not been documented in the resident's chart. "Billing should have informed nursing in IDT (interdisciplinary team). They (Billing) are unable to document in the system."

An interview with the Director of Nursing (DON), Employee #2, was conducted on 7/9/09 at 10:15 AM. She acknowledged a problem in the communication between departments. "PT (Physical Therapy) doesn't chart in electronic charts. Nurses forget to go to the hard chart. Nurses have been left out of the circle. I've been working on a better flow so everybody's aware of what's been done and what the follow-through will be."

Resident #8

Resident #8 was admitted to the facility on 7/2/08, with diagnoses including dysphagia, dementia, Parkinsons Disease, muscle weakness, and hypertension.

Record review revealed the resident had an order for a mechanical soft, nectar thickened liquid diet (NTL). On 7/9/09 at 8:45 AM, the nurse working on the 100 hall, Employee #12, was asked about Resident #8's acceptance of thickened liquids. She indicated that she was unaware that the resident was on a NTL diet. She added, "I give him his potassium without thickened fluids. He might have a problem with choking if he drank it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 48	F 309		

fast, but I give it to him slowly. The order (for NTL) used to be on the MAR."

On 7/9/09 at 12:00 PM, three certified nursing assistants (CNAs) were interviewed regarding their knowledge of thickened liquids. They acknowledged that they prepared thickened liquids for residents wanting a second cup of water or a hot beverage. One CNA stated, "I usually use one teaspoon of thickener." Another CNA related, "I just tell from the texture - it just sort of depends. I use a little more for hot drinks." Still another CNA reported, " I try to level out a tablespoon. I add more as needed to get the right consistency."

A review of the guide for the "ThickenUP" liquid thickener, posted at the 100 hall kitchen, revealed that one tablespoon + one teaspoon of the nectar thickening agent was to be used for 4 ounces of water and hot beverages.

According to the facility's "Hydration Assistance" policy dated 7/08, "Residents who require thickened liquids will have liquids available in the proper consistency to be offered along with hydration pass and activities. The food service supervisor, supervisors over direct care staff, and activity director will train their staff to properly prepare and provide fluid to the residents as scheduled throughout the day."

At 2:00 PM the food service director was interviewed. She indicated that CNAs had been trained in the preparation of thickened liquids on 6/27/08 by a Corporate representative. There was no evidence that staff hired after this date had been trained, or any monitoring of the procedure was being conducted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 49	F 309		

Resident #6

Resident #6 was admitted to the facility on 10/20/06, with a readmission on 6/11/09 after a short 3-day hospital stay.

Record review revealed an order for Depakene (valproic acid) syrup 250 mg/5 mL (milligrams per cubic centimeter) 7.5 cc (cubic centimeters), with a start date of 4/15/08, which was to be given every night for behaviors including "hitting and yelling."

According to the facility's "Psychopharmacologic Drug Usage" policy dated 9/08, "a psychopharmacologic drug is any medication used for managing behavior, stabilizing mood, or treating psychiatric disorders....Consent for the use of psychopharmacologic medications must be given in writing by the resident and/or the resident's representative." Depakene met this definition; however, no consent for the medication was found in the resident's chart.

The nurse on duty, Employee #12, was interviewed on 7/7/09 at 11:15 AM. She confirmed that there was no consent for Depakene. She also indicated that the medication had not been highlighted in the electronic system, as was the normal process for psychotropics. She stated, "Usually it pops up that a consent is needed and we print it out, but it didn't for this medication."

An interview with the social worker (Employee #7) on 7/9/09, confirmed she was involved in the care conferences of the residents. She confirmed that the current care plans of the residents were not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 50 reviewed or updated during these care conferences.	F 309		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to identify and provide services to prevent urinary tract infections for 1 of 20 residents (#13). Findings include: Resident #13 was admitted to the facility on 12/27/07, with diagnoses of muscle weakness, paraplegia, neurogenic bladder, and history of urinary tract infections (UTIs). The resident had a indwelling supra pubic catheter. Review of Resident #13's records including the resident's care plan, nurse's notes, physician's orders and the interdisciplinary care conference notes, revealed appropriate treatment was implemented and followed for UTI occurrences, but failed to reveal evidence that measures for preventing further infections were identified and implemented.	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 52	F 334		

already been immunized;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure that all of the residents in the facility were afforded the opportunity to be immunized against influenza and pneumonia.

Findings include:

In reviewing the records of residents in the sample, it was noted than there was a lack of documentation for completed or refused vaccination for pneumonia and influenza. In an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 53 interview with the Director of Nurses on 7/7/09 at 1120 AM, she revealed that when she assumed the position in January 2009, she found that many of the vaccinations had not given. She further acknowledged that she has immunized approximately 50% of the resident population for pneumonia and was working toward completion for the other 50%. The influenza vaccinations will resume in the fall.	F 334		
F 364 SS=E	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that food was served at the proper temperature. Findings include: Lunch service was observed at the 300 hall kitchen on 7/6/09 at 12:00 PM. Just before the food was plated, the temperatures of the pureed noodles and vegetables were 130 degrees and 122 degrees Fahrenheit (F) respectively. At the 200 hall kitchen at 12:15 PM, the temperature of the pureed green beans was 131 degrees F. The Food Service Supervisor, Employee #5, present during the temperature checks at the 300 hall kitchen, indicated her expectation was that hot foods were to remain at 140 degrees F or above during tray line, as outlined in the facility's Meal Service policy, dated 7/08.	F 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	Continued From page 54 When residents were asked about the temperatures of hot food during the group interview on 7/7/09 at 10:00 AM, one resident responded, "It's more cold than warm." Two others in the group concurred with the opinion that hot foods were not always served at the desired temperature.	F 364		
F 371 SS=E	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the facility did not maintain sanitary conditions for the storage and preparation of food. Findings include: A tour of the facility's main kitchen and three satellite kitchens on 7/6/09 revealed the following: A dietary aide at the 300 hall kitchen was observed putting on her gloves at the lunch tray line at 12:00 PM without first washing her hands. On the steam table, one container of food was stacked on another. The temperatures of the pureed noodles and vegetables were 130	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 55	F 371		

degrees and 122 degrees Fahrenheit (F) respectively. The Food Service Supervisor, Employee #5, was present during the temperature checks, and she indicated that her expectation was that hot foods were to remain at 140 degrees F or above during tray line. According to the facility's Meal Service policy dated 7/08, "Hot foods will be served at 140 degrees F or above."

At the 200 hall kitchen at 12:15 PM, it was observed that there was no water in the steam table. The dietary aide indicated that the reason there was no water was that she had forgotten to bring dividers. The temperature of the pureed green beans was 131 degrees F. The Food Service Supervisor later indicated that all steam tables were supposed to be filled with water and heated before meal service.

There were two dented cans in the the dry storage room.

On 7/10/09 at 10:10 AM, small containers of cottage cheese dated 7/6/09 were observed on the tray cart at the 300 hall. The Food Service Supervisor was interviewed at 11:00 AM, and she indicated that the kitchen's policy was to discard tray cart snacks after three days.

The survey team's Environmental Health Specialist conducted an inspection of the facility's kitchen on 7/7/09, and the following findings were listed on the Food Service Establishment Inspection Report:

1) The walk-in door gasket was damaged and in need of repair.
2) The copper drain line inside the walk-in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 56 refrigerator was beginning to oxidize and was in need of being repainted. 3) The following items were soiled and in need of cleaning: the blinds over the prep table, the handles on the prep table drawers, and the interior of the microwave. 4) The facility's five microwave ovens did not meet commercial-grade standards.	F 371		
F 387 SS=E	483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN VISITS The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that 6 of 20 residents were seen by a physician with a qualified nurse practitioner making every other required visit, every 60 days (Residents #1, #2, #9, #10, #14, #20), and 1 of 20 residents was not seen during the first 30 days of their admission (Resident #3). Findings include: Resident #1 Resident #1 was admitted to the facility on 5/11/07 with diagnoses that included dementia, hypertension and failure to thrive.	F 387		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 387	Continued From page 57	F 387		

Resident #1 was seen by the physician on 7/15/08. The next three visits on 9/13/08, 9/14/08 and 10/09/08 were done by the nurse practitioner. The physician failed to alternate visits with the nurse practitioner.

The resident was also seen by the physician on 1/10/09 but was not seen by any medical staff again until 5/09/09, a total of 120 days.

Resident #2

Resident #2 had been in the facility since 9/6/07. Diagnoses included dementia, osteoarthritis, and hypertension.

Documentation in physician's progress notes indicate that Resident #2 was seen by the physician on 7/22/08. There is no additional documentation of a medical staff visit until 2/12/09, when the resident's care was assumed by another physician. There was no indication of a physician visit for seven months.

Resident #3

Resident #3 was admitted to the facility on 3/27/09. Her admitting diagnoses included adult failure to thrive, dementia and Alzheimer's disease. She required acute care psychiatric evaluation and was readmitted to the facility on 4/21/09. Her primary physician was the medical director.

Review of the progress note records during the time of 3/27/09 through 7/10/09, revealed Resident #3 was not seen by the primary physician until 6/23/09. The physician

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 387	Continued From page 58	F 387		

documented this was a routine follow-up visit. The only other entries were on 5/23/09 and 5/30/09, by the nurse practitioner. The review of other discipline progress notes revealed entries starting at 3/27/09. Resident #3 was not seen every 30 days for the first 90 days of her admission.

Resident #9

Resident #9 has been a constant resident at the facility since his admission on 1/2/05. His primary diagnoses included dementia, bipolar personality, schizophrenia and anemia. His primary physician was the medical director.

Review of the medical progress notes from 11/10/08 through 7/10/08, revealed the resident was seen by his primary physician on 11/8/08. The nurse practitioner saw him on 1/19/09. Resident #9 was not seen again until 5/22/09, by the primary physician. This was a four month gap between medical visits.

Resident #10

Resident #10 was admitted to the facility on 5/26/05. She was readmitted to the facility on 5/11/09. Her primary diagnoses included dementia, diabetes, anxiety, hypothyroidism, asphasia and dysphasics. Her primary physician was the medical director.

Review of the medical progress notes from 1/1/09 through 7/7/09, revealed Resident #10 was initially seen on 1/8/09 by the nurse practitioner. Through the next 6 months, Resident #10 was seen an additional eight times by the nurse practitioner. Resident #10 was not seen by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 387	Continued From page 59	F 387		

primary physician in seven months.

Resident #14

Resident #14 was admitted to the facility on 3/31/05, and readmitted to the facility on 5/10/07. His primary diagnoses included diabetes, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), anemia, reflux and obesity. His primary physician was the medical director.

Review of the progress note records during the time of 8/2/08 through 7/10/09, revealed the following progress note entries: The nurse practitioner documented she saw the resident on a routine visit on 8/2/08. Three subsequent visits by the nurse practitioner were made for red, itching eye on 8/24/08, redness and warmth to the left ankle on 8/30/08 and a rash to the head on 9/4/08. The primary physician documented he saw Resident #14 on 9/30/09 for a routine visit. Resident #14 was seen by the nurse practitioner on 10/9/08.

The primary physician saw Resident #14 on 1/22/09. This was almost four months between visits (September to January). The primary physician saw Resident #14 again on 6/2/09, five months later. The nurse practitioner saw the resident on 2/15/09, 3/16/09, 3/19/09 and 5/9/09 for non-routine assessments.

Resident #20

Resident #20 was admitted to the facility on 6/12/09, and discharged home on 7/6/090. His primary diagnoses included post surgery care following prostate surgery and COPD. His primary physician was the medical director.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 387	Continued From page 60 Review of Resident #20's progress notes during the time of 6/12/09 through 7/6/09, revealed a progress note was written by the primary physician on 11/11/08, and on 5/22/09. This was approximately six months between primary physician entries. There was only one entry by the nurse practitioner during these six months and that was on 1/19/09, approximately two months after the 11/11/08 physician's visit. An interview with the Administrator on 7/7/09, confirmed the medical director was in the facility several times a week.	F 387		
F 406 SS=D	483.45(a) SPECIALIZED REHABILITATIVE SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure orders for specialized rehabilitative services were provided for 2 of 20 residents (Resident #6, #8). Findings include: Resident #6	F 406		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 406	Continued From page 61	F 406		

Resident #6 was admitted to the facility on 10/20/06, with diagnoses including dementia, hypertension, anxiety, and muscle weakness.

One of the documented problems listed in the resident's care plan was "Resident at risk for unsafe/inadequate po (by mouth) intake/weight loss due to dementia, history of weight loss, dysphagia." The resident was receiving a mechanical soft diet with nectar thickened liquids.

Review of the resident's record revealed the following order, dated 4/6/09: "swallow evaluation for decrease of diet; special instructions: evaluate and treat as indicated." There was no evidence that the order had been completed.

Resident # 8

Resident # 8 was admitted to the facility on 7/2/08, with diagnoses including dysphagia, Parkinsons disease, dementia, and hypertension.

One of the problems documented in the resident's care plan was "Resident has potential for aspiration due to swallowing problems in diagnosis in response to diagnosis of dysphagia." The resident was receiving a mechanical soft diet with nectar thickened liquids.

Review of the resident's record revealed that an order for a swallow evaluation was made on 4/6/09. There was no evidence that the order had been completed.

The facility's therapy services coordinator was interviewed on 7/8/09, and he indicated that during a three-month period between February

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295085	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 406	Continued From page 62 and May of 2009 some swallow evaluations were not conducted, because the facility's contracted speech therapist was not available to the facility at that time. On 7/9/09 at 10:00 AM, the Quality Assurance Nurse, Employee #3, was asked about her expectations regarding swallow evaluations which were ordered for residents during the 3-month period that the facility's contracted speech therapist was not available. She stated, "They should have gone outside to get it done."	F 406		